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	495141	A. BUILDING _____ B. WING _____	03/01/2018

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 2/27/18 through 3/1/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of our agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 2/27/18 through 3/1/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. No complaints were investigated during the survey. The census in this 105 certified bed facility was 88 at the time of the survey. The survey sample consisted of 22 current Resident reviews and 2 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 3/14/18

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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§483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.

§483.10(b) Exercise of Rights.
The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

§483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview and staff interview, the facility staff failed to provide a dignified dining experience in the main dining room for one of 24 residents, Resident #37.

The facility did not have enough bowls in the kitchen to serve breakfast to Resident #37.

Findings were:

Resident #37 was admitted to the facility on 08/18/2017 with the following diagnoses, but not limited to: Psychotic disorders with

1. Bowls were ordered on 2/28/18 to add to inventory.
2. Residents that reside in the facility have the potential to be affected.
3. Bowls will be inventoried for 6 weeks to ensure adequate supply. The Food Service Director will audit meals 5 times per week for adequate number of dishes for all residents.
4. Any issues that arise regarding bowl inventory will be reviewed in monthly QAPI meetings.
5. Date of completion 3/23/18.

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hallucinations, generalized anxiety disorder, major depressive disorder, bipolar disorder, hypertension, cerebrovascular disease, contracture of left hand and chronic obstructive pulmonary disease.

A quarterly MDS (minimum data set) assessment with a reference date of 01/09/2018, assessed Resident #37 as being severely impaired with a cognitive summary score of "03".

On 02/28/2018, this surveyor walked through the dining room at approximately 8:15 a.m. Resident #37 motioned for this surveyor to come to his table. He stated, "Lady...can you get me some food?" Resident #37 was sitting at a table with another resident, neither had been served breakfast. Resident #37 was asked if he was hungry. He stated, "Very....I'm a good person, I'm just crippled and hungry."

Two CNAs (certified nursing assistants) were standing at an open window area of the dining room where the serving line was located. They were asked when Resident #37 would be served. CNA #2 stated, "We are waiting on bowls." This surveyor asked what that meant. She stated, "We don't have enough bowls to serve breakfast, we are waiting for them to wash some so we can serve the residents." The CNAs were asked if the folks in the dining room were the first or second seating for breakfast. CNA #3 stated, "It's the second seating." She was asked when Resident #37 came to the dining room. She stated, "I just brought him up here a few minutes before you came in." A third CNA came into the dining room and spoke with CNA #2 & 3. She stated, "I have the others ready, they are in the hallway. Let me know when I can bring them in."

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CNA #2 & 3 were asked if she was waiting to bring residents in because the bowls were not clean. CNA #3 stated, "Yes."

At 8:30 a.m., clean bowls were brought to the serving line area by OS # 6. He began filling bowls, placing them on trays and handing the trays to the CNAs to serve. When OS # 6 was through plating the food this surveyor asked him what had happened that morning that there were not enough bowls to serve the residents. He stated, "We don't have enough bowls, sometimes when there is a lot that needs to go in bowls we run out...today we had four things that go in bowls...puree bread, puree sausage, puree eggs and oatmeal...we run out of bowls and have to wash them to finish serving." OS #6 was asked why there weren't enough bowls. He stated, "Some of them are glass...we probably break three or four a week...we just have to wash the ones we have to feed everybody until the others come in." OS #6 was asked if the bowls had been ordered. He stated, "Yes."

A meeting was held with the administrator and the DON (director of nursing) on 02/28/2018 at approximately 10:00 a.m. The above information was discussed. The administrator was asked if she was aware of the shortage of bowls in the facility and had she approved any to be ordered. She stated that she was not aware of any problem with bowls and she had not ordered any.

On 02/28/2018 at approximately 1:00 p.m., the district dietary manager and the facility dietary manager came to speak with this surveyor. The district manager stated, "We ordered small and large bowls today." The facility dietary manager was asked if he had been aware that there were

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not enough bowls. He stated, "No."

No further information was obtained prior to the exit conference on 03/01/2018.

F 561 Self-Determination
SS=D CFR(s): 483.10(f)(1)-(3)(8)

§483.10(f) Self-determination.
The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

§483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

§483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.
This REQUIREMENT is not met as evidenced by:
Based on resident interview and staff interview

F 550

F 561

1. Resident to exercise autonomy regarding interests and preferences. Guardian took resident for a car ride.
2. Residents that reside in the facility have the potential to be affected.
3. The Administrator will ensure appropriate staff members are trained to drive the van
4. The number of van drivers will be discussed during monthly QAPI meeting and additional drivers will be trained as needed.
5. Date of completion 3/23/18.

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the facility staff failed to ensure one of 24 residents in the survey sample had the opportunity to exercise autonomy regarding interest and preferences. Resident # 46 verbalized wanting to go outside the facility for sight-seeing activities.

Findings include:

Resident # 46 was admitted to the facility 8/7/15 with diagnoses to include, but not limited to: respiratory failure, muscle weakness, dementia, high blood pressure, heart disease, GERD, and depression.

The most recent MDS (minimum data set) was a quarterly review dated 1/16/18 and had R 46 assessed as cognitively intact with a total summary score of 15 out of 15.

On 02/27/2018 at approximately 10:30 a.m., R 46 was observed self-propelling down the hall in his wheelchair. When he saw this surveyor, he stated, "Ma'am can I ask you a question?" This surveyor introduced herself and he stated, "I want to know why I can't get out of here for a little while ....at other places I lived they took me out for a ride, maybe to the river to watch the kids fish, look at the water ...I don't even need to fish I just want to go and sit and watch ...I have worked my days and now I want to feel like I am living a little bit, not in jail ...I feel like I am in jail here." (This was told to another survey team member during the initial pool process).

On 2/27/18 at 3:00 p.m. this writer was talking to R 46 in the hallway, and he verbalized much of the conversation documented above to this

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surveyor as well, adding that when he asked about going for a car ride, he was told he could not due to insurance purposes. R 46 further stated "I would just like to ride out and see the squirrels playing in the trees, watch the kids fish, and just get out of here for a while! There's got to be more to life than looking at these walls all the time."

On 3/1/18 at 10:10 a.m. the facility social worker (SW) was asked about the resident's comments. The SW stated "He asked me if I would take him for a ride in my personal car; that's where the insurance comment is coming from." The SW was then asked if there was transportation available at the facility for the resident to access. The SW told this writer "Yes, we have a van; he also has a guardian who comes to see him about once a month. She is reluctant to take him out for fear of not being able to get him in and out of the car." The SW was asked how long had the facility had the van,and why residents were not taken on outings. She replied "We've had the van about eight years, but we only have one person certified to drive it; the maintenance person. We did have a driver, but when they quit we only had one....the other driver has been gone about a year to a year and a half. I don't know what attempts have been made to get another driver. They have to pass the DOT (department of transportation) physical before they can be certified."

On 3/1/18 during a meeting with facility staff beginning at 10:30 a.m. the administrator and DON (director of nursing) were made aware of the above findings. The administrator stated "I came on board here in September [2017] and I wasn't aware there was no one to drive the van

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F 561	Continued From page 7 except maintenance. I reached out to corporate and they did not want to hire outside the company, so we are in the process of getting people trained, including the activity director." The DON stated "We have told his guardian we will help her with the resident in and out of the car, whatever she needs." When asked about the time frame from when the driver quit to present without having a driver, the administrator stated again "We are in the process of getting some people trained." No further information was provided prior to the exit conference.	F 561		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly,	F 584		

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and comfortable interior;

§483.10(i)(3) Clean bed and bath linens that are in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to ensure a comfortable, homelike environment on one of three nursing units. Resident rooms on C wing had damaged walls, closets and sink cabinets. Residents on C wing reported the shower and whirlpool rooms were cold during use.

The findings include:

1. Resident rooms on C wing had damaged walls, closets and a sink cabinet.

On 2/27/18 at 7:55 a.m., room 11 on C wing was observed. The resident's closet door had a large scraped area with missing paint below the handle along with multiple scratches.

1. The air temperature in the shower room was increased on C wing to make it comfortable for the residents. Staff to document environmental needs in the maintenance log book on each unit.
2. Residents that reside on C wing in the facility have the potential to be affected.
3. The air temperatures will be checked in the C wing shower room weekly and the maintenance log book will be reviewed weekly for facility needs.
4. Any environmental issues will be reviewed monthly in QAPI.
5. Date of completion 3/23/18.

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On 2/27/18 at 9:54 a.m., room 3 on C wing was observed with damaged, puckered wall board above the sink backsplash. The cabinet surface around the sink was brown with caulking missing around the sink border. The sink cabinet had a gap along the front edge. Sections on the resident's closet door and drawers had paint scraped/missing.

On 2/27/18 at 2:51 p.m., room 1 on C wing was observed with a large section of wall damage behind the bed. Wallpaper and dry wall behind the first bed near the floor had linear scraped areas approximately 12 inches in length. The damaged area was approximately 18 inches wide.

On 2/28/18 at 7:55 a.m., the registered nurse unit manager (RN #1) was shown the damaged areas and was interviewed about needed repairs. RN #1 stated items needing repair were supposed to be recorded in a maintenance log kept at the nursing station. RN #1 stated the above items had not been added to the maintenance book. RN #1 stated the room items in disrepair needed to be reported to maintenance.

On 2/28/18 at 8:30 a.m., the maintenance director was interviewed about the resident room items in disrepair on C wing. The maintenance director stated the wall damage in room 1 was most likely due to the bed. The maintenance director stated the specific room items needing repair had not been reported to maintenance.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/28/18 at 10:00 a.m.

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2. Residents on C wing reported the shower and whirlpool rooms were cold during use.

On 2/27/18 at 9:54 a.m., Resident #42 was interviewed about quality of life in the facility. When asked about comfortable temperatures in the facility, Resident #42 stated the shower room on C wing was always cold. Resident #42 stated she did not think there was heat in the shower room. Resident #42 stated sometimes she chose not to take a shower because the room was so cold. Resident #42 stated the water temperatures were fine but the room temperature was not comfortable during showers.

On 2/27/18 at 12:14 p.m., Resident #44 was interviewed about quality of life in the facility. Resident #44 stated during this interview that the shower room and whirlpool room were cold. Resident #44 stated the water temperatures were comfortable but the room temperature was cold.

On 2/28/18 at 1:36 p.m., the certified nurses' aide (CNA #1) routinely working on C wing was interviewed about the shower/whirlpool room temperatures. CNA #1 stated residents complained about the cold shower room "all the time." CNA #1 stated there was a vent and a heat lamp panel in the ceiling of each room but residents still complained about being cold when showered. CNA #1 stated she had worked in the facility for years and the rooms had always been cold.

On 2/28/18 at 1:43 p.m. the registered nurse unit manager (RN #1) was interviewed about resident comments regarding cold bath/shower rooms. RN #1 stated she was not aware of any

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F 584	Continued From page 11 complaints about cold shower rooms. These findings were reviewed with the administrator and director of nursing during a meeting on 3/1/18 at 10:15 a.m.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review, and staff interviews, the facility staff failed, for one of 24 residents in the survey sample (Resident # 13), to accurately assess the resident's ability to eat. Resident # 13, who was assessed as needing extensive assistance with one person physical assist for eating, was observed being fed by staff. The findings were: Resident # 13 in the survey sample, a 92 year-old male, was admitted to the facility on 9/23/12, and readmitted on 10/18/12 with diagnoses that included dementia with behavior disturbance, generalized muscle weakness, right and left knee pain, cellulitis of the left lower limb, left eye glaucomatous optic atrophy, age related nuclear cataracts, arthritis, Non-Alzheimer's dementia, and Alzheimer's Disease. According to the most recent Minimum Data Set (MDS), a Quarterly with an Assessment Reference Date of 12/15/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired	F 641	1. Resident #13 MDS was modified on 3/12/18 for accurate coding of eating in Section G. 2. Residents that reside in the facility are at risk for being affected. 3. MDS Coordinators were re-educated on 3/12/18 on accurate coding for ADLs 4. Any coding issues regarding eating will be reviewed and discussed in QAPI monthly. 5. Date of completion 3/23/18.	

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daily decision making skills.

Under Section G (Functional Status), the resident was assessed as needing extensive assistance with one person physical assist for eating. According to the CMS RAI Manual, extensive assistance with one person physical assist for eating indicates that, "Resident partially participated in the task daily at each meal, but one staff member provided weight bearing assistance with some portion of each meal." (Ref. CMS's RAI Version 3.0 Manual, October 2016, Chapter 3, page G-18.)

At approximately 8:45 a.m. on 2/28/18, Resident # 13 was wheeled into the Dining Room for breakfast. The resident was placed at a table by himself, and the staff member who brought him in asked if he wanted a cup of coffee. While the staff member prepared the cup of coffee, Resident # 13 impatiently tapped his fist on the table.

As soon as the resident received the cup of coffee, a second staff member, later identified as CNA # 6 (Certified Nursing Assistant), moved the cup of coffee to another table, and then moved Resident # 13 to the same table. Another resident was already seated at the second table and was being fed by another CNA.

When Resident # 13's tray arrived at the table, CNA # 6 set-up the meal by adding salt, pepper, and butter to various food items. CNA # 6 placed a small glass of juice in Resident # 13's hand, which he proceeded to slowly drink. After drinking some of the juice, Resident # 13 put the glass on the table. CNA # 6 then proceeded to feed Resident # 13.

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Approximately half was through the meal, CNA # 6 was replaced by another CNA, who continued to feed the resident. CNA # 6 was then interviewed regarding Resident # 13's eating status. "He is a total feed," CNA # 6 said. "We like to bring him in (the Dining Room) after the others. He likes to make noises."

At 2:40 p.m. on 2/28/18, CNA # 6 was interviewed again regarding Resident # 13's eating status. "He can handle a cup or a glass," CNA # 6 said, "But as for a fork or a spoon, we have to do it for him."

At 2:40 p.m. on 2/28/18, RN # 3 (Registered Nurse), one of the MDS Coordinators, was interviewed and given a hypothetical eating situation. Asked if a resident who can hold a glass or a cup to drink, but who must otherwise be fed by staff, should be assessed as needing extensive assistance or as totally dependent, RN # 3 thought for a moment and then said she thought the resident should be assessed as totally dependent.

During an end of day meeting at 3:15 p.m. on 2/28/18, that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team, the assessment of Resident # 13's eating status was discussed.

F 645 SS=D PASARR Screening for MD & ID
CFR(s): 483.20(k)(1)-(3)

F 645

§483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability.

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§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with:
(i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services; or
(ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission-
(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
(B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

§483.20(k)(2) Exceptions. For purposes of this section-
(i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.
(ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission

1. PASSARS for resident #17 and #61 were faxed to facility. Screening set up for #44.
2. Residents that have diagnosis of mental illness and/or disorder in the facility have the potential to be affected.
3. Resident charts audited to ensure PASSAR in place where appropriate. Admissions will obtain PASSAR on new admissions.
4. Any issues with PASSARS to be reviewed and discussed monthly in QAPI.
5. Date of completion 3/23/18.

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to a nursing facility of an individual-
(A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital,
(B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and
(C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services.

§483.20(k)(3) Definition. For purposes of this section-
(i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1).
(ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain a PASARR (preadmission screening and resident review) for three of 24 residents in the survey sample. Residents #17, #44 and #61, diagnosed with mental illness and/or disorders, had no record of preadmission screening and resident reviews.

The findings include:

1. Resident #17, diagnosed with psychosis had no PASARR.

Resident #17 was admitted to the facility on 6/30/17 with diagnoses that included psychosis,

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history of behaviors, COPD (chronic obstructive pulmonary disease), dementia, kidney disease and peripheral vascular disease. The minimum data set (MDS) dated 12/19/17 assessed Resident #17 with moderately impaired cognitive skills.

Resident #17's clinical record documented no evidence of a PASARR prior to or after admission to the facility.

On 2/28/18 at 1:49 p.m., the facility's social worker was interviewed about a PASARR for Resident #17. The social worker stated Resident #17 was admitted from a psychiatric facility. The social worker stated she called the psychiatric facility and they did not have access to the PASARR. The social worker stated, "We don't have a level I assessment [initial PASARR] on him [Resident #17]."

These findings were reviewed with the administrator and director of nursing during a meeting on 2/28/18 at 10:15 a.m.

2. Resident #61, diagnosed with PTSD (post-traumatic stress disorder) had no PASARR.

Resident #61 was admitted to the facility on 5/5/15 with a re-admission on 9/5/16. Diagnoses for Resident #61 included PTSD, quadriplegia, anxiety and depression. The minimum data set (MDS) dated 1/25/18 assessed Resident #61 with moderately impaired cognitive skills.

Resident #61's clinical record documented no evidence of a PASARR prior to or after admission to the facility.

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On 2/28/18 at 1:46 p.m., the facility's social worker was interviewed about a PASARR for Resident #61. The social worker stated the resident came from a hospital to the facility. The social worker stated at the time of Resident #61's admission the hospital was not sending PASARR documentation. The social worker stated she called the hospital and was unable to get the PASARR. The social worker stated she did not have a level I assessment for Resident #61.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/28/18 at 10:15 a.m.

#3. The facility staff failed to ensure Resident 44 had a preadmission screening (PASARR), prior to admission to the facility.

Resident # 44 was admitted to the facility on 04/27/2015. Diagnoses including, but were not limited to: anxiety, depression, manic depression (bipolar disorder), and schizophrenia.

The most current MDS (minimum data set) was a significant change assessment dated 01/15/18, which assessed the resident with a cognitive score of "10", indicating the resident had moderate impairment in daily decision making skills.

Resident # 44 triggered for 'No PASSAR II with diagnosis' in the resident's care area.

During clinical record review for Resident # 44, no preadmission screening of any kind could be

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F 645	Continued From page 18 located. On 02/28/18 at 1:52 p.m., the SW (social worker) was interviewed and stated in regards to resident # 44's PASARR, he (the resident) had came in originally from the hospital as skilled and that the hospital did not send the 9596 form (form used to determine if the resident needed a level I PASARR). The SW stated that the resident was supposed to be short term for skilled services, but ended up becoming long term care and we (the facility) did not get any information from the hospital. The SW stated that the UAI (uniform assessment instrument) was not completed at the hospital. The SW then stated that, they (the facility) did not do any type of screening for this resident. The administrator and DON (director of nursing) were made aware of concerns on 03/01/18 at approximately 10:15 a.m. of the above information. No further information and/or documentation was provided prior to the exit conference on 03/01/18 at 12 noon.	F 645		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the	F 657		

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resident.
(C) A nurse aide with responsibility for the resident.
(D) A member of food and nutrition services staff.
(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.
(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.
(iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and medical record review, the facility staff failed to invite and document resident attendance to a care plan meeting for one of 24 residents, Resident #12 (R 12).

The facility could not show evidence that Resident #12 was invited, attended or reason for not attending care plan meetings.

Findings include:

R 12 was admitted to the facility originally on 09/1/18. The most current MDS (minimum data set) was a significant change assessment dated 12/11/17. R 12 was assessed with a cognitive score of 15, indicating cognitively intact.

On 02/27/18 at 09:46 AM during a resident

1. Resident #12 invited to care plan meeting and attendance documented.
2. Residents that reside in the facility have the potential to be affected.
3. The social worker implemented a reminder card to residents regarding care plan meeting. Social worker will document attendance or refusal to attend care plan meeting.
4. Any issue with process will be discussed in QAPI monthly.
5. Date of completion 3/23/18.

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F 657	Continued From page 20 interview R 12 verbalized that he hasn't been invited to care plan meeting. On 03/01/18 at 07:50 AM the social worker was interviewed regarding care plan meetings with R 12. The SW reviewed a care plan meeting log book and reviewed R 12's medical record and was unable provide documentation that R 12 was invited or attended initial care plan meeting in September 2017 (SW verbalized a care plan meeting was due 72 hours after admission) and December 2017 (12/11/17 was due). There was also no evidence in the resident's medical record indicating that the resident was determined not practicable for attending the care plan meetings. On 3/1/18 at 10:20 AM the above information was presented to the administrator and director of nursing during a facility surveyor meeting. No other information was presented prior to exit conference on 3/1/18	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to provide nail care for one of 24 residents, Resident #51. Resident #51 was observed with long, thick, yellow nails on her toes.	F 677		

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Findings were:

Resident #51 was admitted to the facility on 12/07/2013 with the following diagnoses, but not limited to: hypertension, major depressive disorder, intellectual disabilities, Alzheimer's disease, and esophageal reflux disease.

A significant change MDS (minimum data set) assessment, dated 1/17/2018, assessed Resident #51 as being moderately impaired with a cognitive summary score of "12".

On 02/27/18 at approximately 9:30 a.m., Resident #51 was observed self propelling her wheelchair with her feet. She had a nonslip sock on her right foot, no sock on the left. The toenails of her left foot were observed to be long, yellow, thick and slightly curved on the end. Resident #51 was asked where her sock was for her left foot. She stated, "I don't know...but my little toe is sore." She was asked if she had reported that to the staff. She stated, "No."

This surveyor went up the hall and got LPN (licensed practical nurse) #3. She looked at the pinky toe on the left foot and stated that it was a little red and she would get (Name of wound nurse) to look at it. LPN #3 was asked about the length of Resident #51's toenails. She stated the wound nurse would look at those as well.

At approximately 9:40 a.m., the wound nurse came to look at Resident #51's toes. She stated she was going to let the doctor know the toe was red. She was asked about the length of Resident #51's toenails. She stated that Resident #51 was on the list to see the podiatrist. She then left the

1. Toenail care was given and resident was added to the next podiatrist list.
2. Toenail audit to be completed prior to March podiatry visit.
3. Any toenail concerns will be identified and addressed during bath. Any concerns requiring podiatry services will be added to the podiatry visit list.
4. Bath sheets will be reviewed weekly for 3 months in committee meetings for follow up toenail care. Staff will be inserviced on toenail process. Any toenail care refusal or podiatry visit refusal to be documented as occurs.
5. Date of completion 3/23/18.

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room and returned with nail clippers. She then trimmed Resident #51's toenails. She stated, "I went on and cut them, it looks like the toenails are rubbing the other toes...the areas are not open...the podiatrist will be here in March...he comes every three months and she is on the list." The wound nurse was asked if staff looked at the nails between podiatry visits. She stated, "Yes, they should."

The clinical record was reviewed. A podiatrist note dated 09/28/2017 was observed. The note contained the following: " Schedule 3 month follow-up...Pt seen for new/f/u [follow-up] and nail evaluation and treatment. No new complaints Bilateral Hallux [big toe] nails are mildly mycotic and mildly ingrown." There were no podiatrist notes for December.

A meeting was held with the administrator and the DON (director of nursing) on 02/28/2018 at approximately 10:00 a.m. The above information was discussed. Copies of the December podiatry note, if available were requested.

At approximately 4:00 p.m. LPN (licensed practical nurse) #1 presented a note from the podiatrist stating that Resident #51 had refused her appointment on 12/28/2017. The note had just been faxed to the facility. LPN #1 was asked if there was any documentation in the clinical record regarding the attempted to visit. She stated, "No.'

An end of survey meeting was held on 03/01/2018 with the administrator and the DON. The above information was discussed. The administrator stated that she had reviewed the record and Resident #51 was seen by the

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F 677	Continued From page 23 podiatrist due to her hammer toes. She was asked if the nails were long would she expect staff to trim them up. She stated, "Yes." No further information was obtained prior to the exit conference on 03/01/2018.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, the facility staff failed to follow physician orders for two of 24 residents, Resident #51 and Resident #20. 1. Resident #51 was not wearing physician ordered TED hose on 02/27/2018. 2. Facility staff were not tracking the amount of fluid consumed by Resident #20, who was on a physician ordered 1000 ml per day fluid restriction. Findings were: 1. Resident #51 was not wearing physician ordered TED hose on 02/27/2018.	F 684	1. Ensure resident is wearing TED hose as ordered and refusals to wear documented. 2. Any other residents with TED hose ordered monitored for proper use. 3. Weekly care keeper rounds to ensure TED hose on as ordered. 4. Weekly audit of TAR for 3 months to ensure proper documentation of TED hose use. Will be reviewed in monthly QAPI meeting. 5. Date of completion 3/23/18.	

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Resident #51 was admitted to the facility on 12/07/2013 with the following diagnoses, but not limited to: hypertension, major depressive disorder, intellectual disabilities, Alzheimer's disease, and esophageal reflux disease.

A significant change MDS (minimum data set) assessment, dated 1/17/2018, assessed Resident #51 as being moderately impaired with a cognitive summary score of "12".

On 02/27/18 at approximately 9:30 a.m., Resident #51 was observed self propelling her wheelchair with her feet. She had a nonslip sock on her right foot, no sock on the left. Her left foot was bare.

The clinical record was reviewed on 02/27/2018 at approximately 10:15 a.m. The following order was observed on the physician order sheet for February 2018: "Apply TED hose to left lower extremity in the morning for edema."

The care plan was reviewed. A focus area: "At risk for impaired cardiovascular status related to HTN [hypertension]" had the following intervention listed: "TED hose LLL [left lower leg] per order." The TAR (treatment administration record) was reviewed. The TED hose for the LLL was signed off as applied at 6:00 a.m., on 02/27/2018.

This surveyor spoke with CNA (certified nursing assistant) #5 who was caring for Resident #51. She was asked about the TED hose. She stated, "I didn't put them on her...I think they do that on night shift." Resident #51 was asked if anyone had offered to put her TED hose on that morning. She stated, "No."

1. Order for I&O received from physician.
2. Orders audited for other resident's with fluid restriction orders.
3. Daily intake recorded on fluid distribution worksheet.
4. Worksheets monitored monthly for 3 months during QAPI.
5. Date of completion 3/23/18.

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A meeting was held with the administrator and the DON (director of nursing) on 02/28/2018 at approximately 10:00 a.m. The above information was discussed.

No further information was obtained prior to the exit conference on 03/01/2018.

2. Facility staff were not tracking the amount of fluid consumed by Resident #20, who was on a physician ordered 1000 ml per day fluid restriction.

Resident #20 was admitted to the facility on 08/25/2017 with the following diagnoses, but not limited to: congestive heart failure, type 2 diabetes mellitus, hypertension, chronic kidney disease, Stage 4 (severe), and chronic obstructive pulmonary disease.

A quarterly MDS (minimum data set) completed on 12/20/2017 assessed Resident #20 as moderately impaired with a cognitive summary score of "11".

On 02/27/18 at approximately 8:00 a.m., Resident #20 was observed sitting up in bed eating her breakfast. Her tray card was observed and included information that Resident #20 was on a 1000 cc per day fluid restriction. Resident #20 was asked if she was on dialysis. She stated, "Not yet". Observed on her breakfast tray was coffee, juice and milk. A bottle of Pepsi was on her bedside table. Resident #20 was asked about her fluid restriction. She stated, "I tell them what I drink, I think they watch and write it down."

The clinical record was reviewed. An order written

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on 08/25/2017 was on the February physician order sheet for: "1000 ml fluid restriction qd [every day] 90 cc with each med pass to = 360 cc, 120 cc with each meal from dietary to = 360 cc 280 cc free water". An additional order regarding fluid restrictions was written on 02/22/2018: "Clarification: 1000 ml fluid restriction every day. 720 ml from dietary and 280 ml from nursing."

The care plan was reviewed. A focus area: "Potential for excessive fluid intake as related to: cardiac disease, end stage renal disease with risk for weight changes, altered fluid volume. Family brings in fluids to resident..." Interventions included: "Fluid restriction as ordered."

The MAR (medication administration record) was reviewed. The order for fluid restrictions was checked off each day by the nursing staff but there were no totals for the amount of fluid consumed by the resident. RN (registered nurse) #1 was asked where the intake of fluids for a resident on fluid restrictions would be tracked. She stated, "We don't track that." A copy of he MAR was requested and obtained at 4:00 p.m., on 02/27/2018. RN #1 was asked what the nurse's initials on the fluid restrictions order meant. She stated, "The initials mean that we are acknowledging that she is on a fluid restriction...we don't track it."

On 02/28/2018 a meeting was held with the DON (director of nursing) and the administrator. The above information was discussed. The DON stated that the facility does not keep track of intake and outputs. She was asked if the physician who ordered the fluid restriction was aware that the amount consumed per day would

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not be tracked. She stated they would contact him.

At approximately 1:00 p.m., LPN (licensed practical nurse) #1 and RN (registered nurse) #2 came to the conference room to speak with this surveyor. LPN #1 stated: "We contacted the physician for clarification about [name of Resident #20] fluid restriction...we are trying to get clarification about the amounts of fluid and that she is noncompliant." This surveyor explained to LPN #1 that the question was not the amounts or the noncompliance, the concern was that the physician had ordered 1000 cc/day fluid restrictions and the facility was not monitoring to see how much she was getting.

RN #2, a unit manager was asked what the expectation was regarding tracking intake for a resident on fluid restrictions. She stated, "We should have a running list of what the resident is getting...it is divided up between nursing. and dining...720 from dietary and 280 from nursing, that includes her medpass... we watch it, like for breakfast she doesn't get coffee and juice, just one or the other." RN #2 was told that on 02/27/2018 during the morning breakfast, Resident #20 had milk, juice and coffee on her tray. RN #2 was asked if anyone wrote down how much she actually took in from the fluids provided on her meal tray or other fluids that she was getting since it was documented that she is noncompliant. She stated, "We don't have a policy on fluid restrictions and we don't do direct I&O [intake and output] per the corporate...when someone has orders for a fluid restriction we check it off on the MAR, the owner doesn't want us to track it."

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F 684	Continued From page 28 On 03/01/2018 a meeting was held with the administrator, the DON and a nurse consultant. Fluid restrictions were again discussed. The administrator stated, "We are getting clarification regarding the fluid restrictions...the doctor ordered fluid restrictions and we acknowledge that on the MAR...he didn't order for us to do I&O's." This surveyor stated the identified concern was not about outputs but about the amount of fluid Resident #20 actually took in each day. The administrator was asked if the physician was aware that the intake amounts were not being tracked and recorded. She stated, "We have a call in to his office...the owner wants a specific order to track the intake." No further information was obtained prior to the exit conference on 03/01/2018.	F 684		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		

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reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:

Based on observations, clinical record review, and staff interview, the facility staff failed, for one of 24 residents in the survey sample (Resident # 13), to provide the resident with a wheelchair having leg and foot rests. Resident # 13, who had a loss of Range of Motion to his lower extremities, was observed being wheeled about the facility in a wheelchair with no leg or foot rests, his legs dangling, and his feet approximately 10 to 12 inches off the floor.

The findings were:

Resident # 13 in the survey sample, a 92 year-old male, was admitted to the facility on 9/23/12, and readmitted on 10/18/12 with diagnoses that included dementia with behavior disturbance, generalized muscle weakness, right and left knee pain, cellulitis of the left lower limb, left eye glaucomatous optic atrophy, age related nuclear cataracts, arthritis, Non-Alzheimer's dementia, and Alzheimer's Disease. According to the most recent Minimum Data Set (MDS), a Quarterly with an Assessment Reference Date of 12/15/17, the resident was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills.

Under Section G (Functional Status), at Item G0400 Functional Limitation in Range of Motion, the resident was assessed as having impairment on both sides of his lower extremity.

During the orientation tour at 10:30 a.m. on 2/27/18, Resident # 13 was observed in the hall

1. Resident #13 chair modified to include footrests.
2. Residents in wheelchairs will be assessed for need of footrests on wheelchairs.
3. Resident's will be assessed weekly on care keeper rounds for proper footrests and therapy screen sent as needed.
4. Will review monthly in committee for 3 months to ensure footrest are in proper use.
5. Date of completion 3/23/18.

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on Unit C, seated in a wheelchair. There were no leg or foot rests on the wheelchair, his legs dangling, and his feet were approximately 10 to 12 inches off the floor.

At 8:40 a.m. on 2/28/18, the Rehab Manager was interviewed regarding Resident # 13's wheelchair and the absence of leg rests and foot rests. The Rehab Manager said the resident was no longer on the Rehab case load, but that at one time, he did have leg and foot rests on his wheelchair. The Rehab Manager said she did not know why he no longer had them.

At 8:45 a.m. on 2/28/18, the resident was observed in the Dining Room, seated in his wheelchair, being fed breakfast. There were no leg rests or foot rests on the wheelchair. His legs were dangling, crossed at the ankle, and he was swinging them back and forth from time to time while being fed.

At 9:25 a.m. on 2/28/18, LPN # 4 (Licensed Practical Nurse), who was passing medications on C-Wing where Resident # 13's room was located, was asked if she was familiar with the resident. LPN # 4 said that she was. Asked why there were no leg rests or foot rests on his wheelchair, LPN # 4 said, "He uses his feet to propel." When told that his legs were dangling and his feet were 10 to 12 inches off the floor, LPN # 4 said, "I did not know that." LPN # 4 then said the legs rests and foot rests were taken off "...because he gets skin tears from them. It is care planned."

A review of Resident # 13's care plan revealed the following problem, initiated 2/4/18, "Potential for alteration in skin integrity r/t (related to):

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F 688	Continued From page 31 incontinence, self-inflicted scratches, picks skin, self-inflicted skin tears and bruises r/t repeatedly banging on walls, doors, and tables. Also, when wheeling self in WC (wheelchair) resident will often receive skin tears and bruising to hands and lower arms and lower extremities." Although the care plan problem mentions "...skin tears and bruising to hands and lower arms and lower extremities...," there was nothing to suggest leg rests and foot rests were the cause of any lower extremity bruising or skin tears. During an end of day meeting at 3:15 p.m. on 2/28/18, that included the Administrator, Director of Nursing, Corporate Nurse Consultant, and the survey team, the absence of leg rests and foot rests on Resident # 13's wheelchair, along with his legs dangling and his feet 10 to 12 inches above the floor were discussed.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide supervision for one of 24 residents, Resident #32 and failed to provide a pull cord for the bathroom call light for one of 24 residents, Resident #42.	F 689		

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1. Resident #32 was observed wandering in and out of resident rooms throughout the facility unsupervised.

2. The call light in Resident #42's bathroom was missing a safety pull cord.

Findings were:

Resident #32 was admitted to the facility on 02/02/2010 with the following diagnoses, including but not limited to: unspecified intellectual disabilities, dementia without behaviors, major depressive disorder, type 2 diabetes mellitus, hypertension and schizoaffective disorder.

A significant change assessment completed on 01/03/2018, assessed Resident #32 as moderately impaired with a cognitive summary score of "11".

On 02/27/2018 the survey team entered the facility. Throughout the day Resident #32 was observed wandering up and down the hallway of the facility. She was ambulatory and had a wanderguard on her right ankle. She was observed going into resident rooms to give candy, cookies and snacks to residents and offering the same to facility staff and this surveyor. Resident #32 was observed going into a resident room, opening the bathroom door and offering the resident on the toilet a coca cola and a fig newton. (The resident in the bathroom declined to be interviewed). Resident #32 was asked where she got her snacks. She pointed to her chest and said, "Mine." Resident #32 began to sing in a foreign language and walked away.

1. Resident #32 was placed one on one to prevent wandering into other resident rooms.
2. Nursing and social worker to identify resident's with behaviors of wandering into other resident rooms.
3. Nursing and social worker to review weekly in committee meeting residents that have the potential for wandering into other resident rooms.
4. Any residents with new behavior of wandering into other resident's room will be identified through monthly QAPI process for 3 months.
5. Date of completion 3/23/18.

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The clinical record was reviewed. The care plan included three focus areas addressing the above observations, "Potential for elopement related to: hx of attempt to elope" and "I sometimes have behaviors which include: ...wanders in/out rooms, takes items..." and "I sometimes have behaviors which include: taking food items and offering or giving them to residents..." Interventions listed for these focus area included but were not limited to: "Redirect patients from doors, offer snacks, fluids of choice, activities of choice; Wanderguard per order; Offer me something I like as a diversion...; Encourage resident to eat snacks in the dining room or in view of staff."

On 02/28/2018 at approximately 10:00 a.m., a meeting was held with the DON (director of nursing) and the administrator. The above information was discussed. Concerns were voiced that Resident #32 was wandering in out of rooms giving cookies and candy to residents with diabetes. Concerns were voiced regarding Resident #32's safety as related to wandering in and out of resident rooms, and walking in on other residents while they were in the bathroom. The administrator stated, "We are trying to find placement her because of that and no one will take her." The administrator was asked what was expected of staff at the facility until additional placement could be located. She stated, "Staff are to redirect her." The administrator and the DON were informed that this surveyor had been on the wing where Resident #32 resided most of the day on 02/27/2018 and not once had staff been observed redirecting Resident #32. When Resident #32 approached staff and offered them something they refused the offering and Resident #32 would go on down the hallway.

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On 03/01/2018 during an end of survey meeting with the administrator and the DON, this surveyor was told that Resident #32 had been placed on 1:1.

No further information was obtained prior to the exit conference.

2. Resident #42's call light in the bathroom was missing a safety pull cord.

Resident #42 was admitted to the facility on 3/30/10 with diagnoses that included high blood pressure, osteoporosis, depression and gastroesophageal reflux disease. The minimum data set (MDS) dated 1/12/18 assessed Resident #42 as cognitively intact and to require only cueing/encouragement for toileting.

On 2/27/18 at 3:21 p.m. Resident #42's bathroom was inspected. The call light beside the toilet was missing a pull cord. The call light had a switch but no cord attached.

Resident #42's plan of care (revised 1/17/18) listed the resident was at risk of falls. Included in interventions for fall prevention was, "Call light or personal items available and in easy reach..."

On 2/27/18 at 3:22 p.m., Resident #42 was interviewed about the missing pull cord. Resident #42 stated the pull cord had been missing "quite awhile." Resident #42 stated she used the toilet independently and did not require assistance from staff for bathroom use.

On 2/28/18 at 8:00 a.m., the registered nurse unit

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manager (RN #1) was interviewed about the call light without a safety cord. RN #1 stated she was not aware of the missing cord. RN #1 stated items needing repair were supposed to be reported to maintenance.

On 2/28/18 at 8:30 a.m., the maintenance director was interviewed about Resident #42's missing call light pull cord. The maintenance director stated he was not aware of the missing cord.

These findings were reviewed with the administrator and director of nursing during a meeting on 2/28/18 at 10:00 a.m.

F 756 SS=D — Drug Regimen Review, Report Irregular, Act On — CFR(s): 483.45(c)(1)(2)(4)(5) — F 756

§483.45(c) Drug Regimen Review.
§483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

§483.45(c)(2) This review must include a review of the resident's medical chart.

§483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.
(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.
(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a

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minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.
(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.

§483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure that the monthly pharmacy drug regimen review was acted upon timely for one of 24 resident, Resident # 63.

The facility staff failed to ensure that the (DRR) monthly pharmacy (drug regimen review) for Resident # 63 was sent to the attending physician and/or medical director for action; the facility additionally failed to develop and maintain policies and procedures for the DRR (drug regimen review) to ensure timeliness of identified concerns. The pharmacy made recommendations for Resident # 63's DRR for November and December (2017) and was not acted upon until January of 2018, and then was not acted upon completely.

Findings include:

1. MD/or NP to further review pharmacy recommendation to address dosage and diagnosis for resident #63.
2. Resident charts audited for any pharmacy recommendations not addressed.
3. Inserviced the MD and NP on pharmacy recommendation process.
4. After pharmacy recommendations reviewed by MD or NP, nursing to ensure that the recommendations were addressed monthly for 3 months.
5. Date of completion 3/23/18.

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Resident # 63 was admitted to the facility on 11/17/17. Admitting diagnoses for Resident # 63 included, but were not limited to: Alzheimer's disease (early onset) with aggression and agitation and insomnia.

The most current full MDS (minimum data set) was a significant change assessment dated 01/26/18. This MDS assessed the resident to have a cognitive score of "3", indicating the resident had severe impairment in daily decision making skills. This MDS assessed the resident as receiving an antidepressant and an antipsychotic (every day) for the previous seven days. The resident triggered in the CAAS (care area assessment summary) section of this MDS for cognition, communication, behaviors and psych drugs.

The resident's admission MDS assessment dated 11/27/17 was reviewed. This MDS assessed the resident as having a cognitive score of "8" indicating moderate impairment in daily decision making skills. This MDS assessed the resident as receiving an antipsychotic medication (every day) for the previous seven days. The resident triggered in the CAAS (care area assessment summary) section of this MDS for cognition, communication and psych drugs.

On 03/01/18 at 07:43 AM, Resident # 63's pharmacy recommendations were reviewed for 11/30/17. The pharmacy review documented, "...Resident [# 63] is on Zyprexa 5 mg [milligrams] QHS [every night at bedtime] for "depression". This is not an approved diagnosis for Zyprexa. Schizophrenia...Bipolar...Schizophrenia or Bipolar

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F 756	Continued From page 38	F 756		

related agitation...****Can this be decreased to Zyprexa 2.5 mg QHS...Please clarify diagnosis. If resident is to remain on this medication outside approved diagnosis please document..."

The pharmacy review form dated 11/30/17 for Resident # 63 had an area for the 'physician/prescriber response' (agree, disagree, other), this area was blank and there was no explanation provided; a hand written entry (side note) documented, "Already done." This recommendation was signed on 01/18/18 by NP (Nurse Practitioner).

Another pharmacy review was found for Resident # 63 dated 12/19/17. The pharmacy review documented, "...Resident [# 63] is on Zyprexa 5 mg [milligrams] QHS [every night at bedtime] for "depression". This is not an approved diagnosis for Zyprexa.
Schizophrenia...Bipolar...Schizophrenia or Bipolar related agitation...****Can this be decreased to Zyprexa 2.5 mg QHS...Please clarify diagnosis. If resident is to remain on this medication outside approved diagnosis please document..."

The pharmacy review form dated 12/19/17 for Resident # 63 had an area for the 'physician/prescriber response' (agree, disagree, other), this area was blank and there was no explanation provided; a hand written entry (side note) documented, "Already done." This recommendation was signed on 01/18/18 by NP (Nurse Practitioner).

These two pharmacy recommendations for Resident # 63 were not addressed until 01/18/18 (7 weeks later) and were still not addressed accurately and/or completely.

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F 756	Continued From page 39	F 756		

A review of the physician's orders for Resident # 63 documented that Resident # 63's Zyprexa 5 mg qhs had started on 11/17/17 (date of admission).

The resident's MARS (medication administration records) documented that the resident received Zyprexa 5 mg qhs for "depression" (from admission 11/17/17 through 12/04/17).

On 12/05/17 through 12/18/17 the MARS documented that Resident # 63 received Zyprexa 5 mg qhs for "Alzheimer's" disease.

The resident then received Zyprexa 5 mg qhs from 12/19/17 through 01/29/18 for "agitation."

On 01/30/18, the resident's diagnosis for Zyprexa 5 mg qhs administration had changed again to "Alzheimer's dementia" and was the present (03/01/18) diagnosis for this medication.

During the above time frame the resident's diagnosis for the use of Zyprexa 5 mg qhs was changed multiple times and was not an approved diagnosis for the use this antipsychotic medication.

The pharmacy recommendations to decrease the Resident # 63's dose of Zyprexa 5 mg to 2.5 mg was not addressed at all.

On 02/22/18 an order was written for Zyprexa 5 mg QHS to be changed to Zyprexa 5 mg QAM (the order was not changed, Zyprexa 5 mg QAM was actually added to an already existing order). The resident then received Zyprexa 5 mg QAM and QHS from 02/22/18 through 02/28/18.

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F 756	Continued From page 40	F 756		

On 03/01/18 at 8:26 AM RN (Registered Nurse) # 5 (unit manager of C wing) was interviewed regarding the process for pharmacy recommendations. RN # 5 stated that [name of pharmacist] comes in and puts stuff [recommendations] in the computer, the DON (director of nursing) then prints it out (from an email received by pharmacy) the DON then gives it [the recommendations] to us [unit managers] and then we [unit managers] will give to physician or NP on next visit. RN # 5 stated that the NP comes in twice a week and the MD [Medical Doctor] comes in once a week. The RN was made aware of the missed pharmacy reviews for Resident # 63 and was asked assistance in determining what happened. The RN stated that she was sure what happened with that.

The RN was then made aware of the physician's order to change the time of Zyprexa 5 mg, not add to the existing order and was asked if the nurses complete a 24 hours check in order to ensure medications orders are correct and accurate. The RN stated that as far as 24 hour checks for physician's orders, "we [nurses] don't sign" we do them everyday, but we [unit managers] don't sign. The RN was asked if there is not signature then how does she and/or facility know that the 24 hour check has been done and completed. The RN stated, "I see what your saying, if we don't sign it, how will you know that it was done." The RN was then asked for a policy on 24 hours checks and a policy on pharmacy reviews to ensure that they are completed timely and addressed accurately. The RN stated, "I don't think we have a policy on either the pharmacy review or the 24 hours checks, but I'll check."

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F 756	Continued From page 41	F 756		

On 03/01/18 at 9:19 AM RN # 5 presented copies of requested information from Resident # 63's medical record.

03/01/18 at 10:26 AM, A team meeting with the DON (director of nursing) and the administrator was conducted. The DON and administrator were made aware of the above information and concerns surrounding the delay response for two pharmacy recommendations, the lack of appropriate diagnosis for the use of an antipsychotic, and the medication error/unnecessary use of an antipsychotic medication for Resident # 63. The DON and administrator stated that the facility does not have policies on 24 hour [order] checks for nurses to complete and stated that the facility does not have a policy on pharmacy reviews to ensure that they are completed timely and/or accurately. The DON stated that the expectation would be to review orders and pharmacy recommendations in the morning meeting and any follow up at that point would be done.

The DON and administrator then stated that the pharmacy review process is that the pharmacist comes in, does the review, and then the pharmacist will email the recommendations to administrator and DON and then, either the administrator and/or DON will give the recommendations to unit managers, at that point the nurses will give the recommendations to the NP (nurse practitioner) or the physician,. The DON stated, those [pharmacy recommendations] are usually done the same day, but could not explain how Resident # 63 had the same recommendations, two months in a row and were not addressed until 7 weeks later. The DON and

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F 756	Continued From page 42 administrator stated that there is no form of documentation to verify the completion of 24 hour checks done by the nurses and there is no documentation forms and/or policy to ensure that the pharmacy recommendations are addressed timely, completely and accurately. No further information and/or documentation was presented prior to the exit conference on 03/01/18.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F 758	1. Resident #63 orders reviewed by MD to ensure proper drug regimen. 2. Nursing to review past 3 months of pharmacy recommendations to ensure orders are correct. 3. Nursing to review order to order weekly. 4. Processes for orders to be reviewed monthly in QAPI for 3 months. 5. Date of completion 3/23/18.	

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F 758	Continued From page 43	F 758		

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

§483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure that one of 24 residents was free from an unnecessary psychotic medication, Resident # 63.

The facility staff failed to ensure that Resident # 63 had an approved diagnosis for the use of the antipsychotic medication (Zyprexa) and failed to ensure a GDR (gradual dose reduction); the resident's dose reduction was not addressed and was actually increased in error by the facility nursing staff. The resident was not free of unnecessary psychotic medications.

Findings include:

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F 758	Continued From page 44	F 758		

Resident # 63 was admitted to the facility on 11/17/17. Admitting diagnoses for Resident # 63 included, but were not limited to: Alzheimer's disease (early onset) with aggression and agitation and insomnia.

The most current full MDS (minimum data set) was a significant change assessment dated 01/26/18. This MDS assessed the resident to have a cognitive score of "3", indicating the resident had severe impairment in daily decision making skills. This MDS assessed the resident as receiving an antidepressant and an antipsychotic (every day) for the previous seven days. The resident triggered in the CAAS (care area assessment summary) section of this MDS for cognition, communication, behaviors and psych drugs.

The resident's admission MDS assessment dated 11/27/17 was reviewed. This MDS assessed the resident as having a cognitive score of "8" indicating moderate impairment in daily decision making skills. This MDS assessed the resident as receiving an antipsychotic medication (every day) for the previous seven days. The resident triggered in the CAAS (care area assessment summary) section of this MDS for cognition, communication and psych drugs.

On 03/01/18 at 07:43 AM, Resident # 63's pharmacy recommendations were reviewed for 11/30/17. The pharmacy review documented, "...Resident [# 63] is on Zyprexa 5 mg [milligrams] QHS [every night at bedtime] for "depression". This is not an approved diagnosis for Zyprexa. Schizophrenia...Bipolar...Schizophrenia or Bipolar related agitation...****Can this be decreased to

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Zyprexa 2.5 mg QHS...Please clarify diagnosis. If resident is to remain on this medication outside approved diagnosis please document..."

The pharmacy review form dated 11/30/17 for Resident # 63 had an area for the 'physician/prescriber response' (agree, disagree, other), this area was blank and there was no explanation provided; a hand written entry (side note) documented, "Already done." This recommendation was signed on 01/18/18 by NP (Nurse Practitioner).

Another pharmacy review was found for Resident # 63 dated 12/19/17. The pharmacy review documented, "...Resident [# 63] is on Zyprexa 5 mg [milligrams] QHS [every night at bedtime] for "depression". This is not an approved diagnosis for Zyprexa.
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These two pharmacy recommendations for Resident # 63 were not addressed until 01/18/18 (7 weeks later) and were still not addressed accurately and/or completely.

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F 758	Continued From page 46	F 758		

A review of the physician's orders for Resident # 63 documented that Resident # 63's Zyprexa 5 mg qhs had started on 11/17/17 (date of admission).

The resident's MARS (medication administration records) documented that the resident received Zyprexa 5 mg qhs for "depression" (from admission 11/17/17 through 12/04/17).

On 12/05/17 through 12/18/17 the MARS documented that Resident # 63 received Zyprexa 5 mg qhs for "Alzheimer's" disease.

The resident then received Zyprexa 5 mg qhs from 12/19/17 through 01/29/18 for "agitation."

On 01/30/18, the resident's diagnosis for Zyprexa 5 mg qhs administration had changed again to "Alzheimer's dementia" and was the present (03/01/18) diagnosis for this medication.

During the above time frame the resident's diagnosis for the use of Zyprexa 5 mg qhs was changed multiple times and was not an approved diagnosis for the use this antipsychotic medication.

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F 758	Continued From page 47	F 758		

On 03/01/18 at 8:26 AM RN (Registered Nurse) # 5 (unit manager of C wing) was interviewed regarding the process for pharmacy recommendations. RN # 5 stated that [name of pharmacist] comes in and puts stuff [recommendations] in the computer, the DON (director of nursing) then prints it out (from an email received by pharmacy) the DON then gives it [the recommendations] to us [unit managers] and then we [unit managers] will give to physician or NP on next visit. RN # 5 stated that the NP comes in twice a week and the MD [Medical Doctor] comes in once a week. The RN was made aware of the missed pharmacy reviews for Resident # 63 and was asked assistance in determining what happened. The RN stated that she was sure what happened with that.

The RN was then made aware of the physician's order to change the time of Zyprexa 5 mg, not add to the existing order and was asked if the nurses complete a 24 hours check in order to ensure medications orders are correct and accurate. The RN stated that as far as 24 hour checks for physician's orders, "we [nurses] don't sign" we do them everyday, but we [unit managers] don't sign. The RN was asked if there is not signature then how does she and/or facility know that the 24 hour check has been done and completed. The RN stated, "I see what your saying, if we don't sign it, how will you know that it was done." The RN was then asked for a policy on 24 hours checks and a policy on pharmacy reviews to ensure that they are completed timely and addressed accurately. The RN stated, "I don't think we have a policy on either the pharmacy review or the 24 hours checks, but I'll check."

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F 758	Continued From page 48	F 758		

On 03/01/18 at 9:19 AM RN # 5 presented copies of requested information from Resident # 63's medical record.

03/01/18 at 10:26 AM, A team meeting with the DON (director of nursing) and the administrator was conducted. The DON and administrator were made aware of the above information and concerns surrounding the delay response for two pharmacy recommendations, the lack of appropriate diagnosis for the use of an antipsychotic, and the medication error/unnecessary use of an antipsychotic medication for Resident # 63. The DON and administrator stated that the facility does not have policies on 24 hour [order] checks for nurses to complete and stated that the facility does not have a policy on pharmacy reviews to ensure that they are completed timely and/or accurately. The DON stated that the expectation would be to review orders and pharmacy recommendations in the morning meeting and any follow up at that point would be done.

The DON and administrator then stated that the pharmacy review process is that the pharmacist comes in, does the review, and then the pharmacist will email the recommendations to administrator and DON and then, either the administrator and/or DON will give the recommendations to unit managers, at that point the nurses will give the recommendations to the NP (nurse practitioner) or the physician,. The DON stated, those [pharmacy recommendations] are usually done the same day, but could not explain how Resident # 63 had the same recommendations, two months in a row and were not addressed until 7 weeks later. The DON and administrator stated that there is no form of

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F 758	Continued From page 49 documentation to verify the completion of 24 hour checks done by the nurses and there is no documentation forms and/or policy to ensure that the pharmacy recommendations are addressed timely, completely and accurately. No further information and/or documentation was presented prior to the exit conference on 03/01/18.	F 758		
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, the facility staff failed to provide food that was palatable and at the preferred temperature for one of 24 residents, Resident #20. During breakfast on 02/27/2018, Resident #20 was served scrambled eggs that were cold, and hard. Per Resident #20, "It looks like they scraped them off the bottom of the pan." Findings were: Resident #20 was admitted to the facility on 08/25/2017 with the following diagnoses, but not	F 804	1. Resident #20 received new eggs that were palatable. 2. Residents that reside in the facility have potential to be affected. 3. The Food Service Director will do a test tray 5 times a week for 6 weeks to ensure palatable food is given to the residents. 4. Any issues that may arise will be discussed and reviewed in monthly QAPI. 5. Date of completion 3/23/18.	

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F 804	Continued From page 50	F 804		

limited to: congestive heart failure, type 2 diabetes mellitus, hypertension, chronic kidney disease , Stage 4 (severe), and chronic obstructive pulmonary disease.

A quarterly MDS (minimum data set) completed on 12/20/2017 assessed Resident #20 as moderately impaired with a cognitive summary score of "11".

On 02/27/18 at approximately 8:00 a.m., Resident #20 was observed sitting up in bed eating her breakfast. This surveyor introduced herself and asked Resident #20 about her breakfast. She stated, "It's awful...they slopped white gravy over a biscuit, I'm not eating that...I'm suppose to have an egg, it's on the card [pointing to her tray card], but I didn't get one and there was no meat either." Resident #20's tray card was reviewed. Scrambled eggs were listed as an item that she was to be served.

The social worker for the facility was in the hallway. She overheard the conversation and came into the room. She stated, "I'll go check on her eggs...I know we ran out of sausage and bacon until the truck comes, that's why we have the gravy biscuits, but I'm not sure why she doesn't have eggs." She went to the kitchen and returned to Resident #20's room. She stated, "They ran out of eggs this morning." She was asked if the kitchen could prepare eggs for Resident #20. The social worker again left the room and returned with a black cereal bowl of scrambled eggs. Resident #20 took a bite of the eggs and stated, "Look at these...it looks like they scraped them off of the bottom of the pan...they're dry." Resident #20 was asked if they tasted okay. She stated, "No, they don't."

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	495141	A. BUILDING _____ B. WING _____	03/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGHANY HEALTH AND REHAB	1725 MAIN STREET CLIFTON FORGE, VA 24422

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F 804	Continued From page 51	F 804		

The social worker stated ,"They had fried eggs this morning too...let me go see if I can get her one of those." The Social worker returned to the kitchen and returned with a fried egg and a piece of toast for Resident #20. Resident #20 stated, "Thank you...I can eat this."

A meeting was held with the administrator and the DON (director of nursing) on 02/28/2018 at approximately 10:00 a.m. The above information was discussed.

On 02/28/2018 at approximately 1:00 p.m., the district dietary manager and the facility dietary manager came to speak with this surveyor. The above situation was discussed. The facility dietary manager was asked what had happened on Tuesday (2/27/18) that Resident #20 didn't get eggs. He stated "We fix what we think we need for the number of residents we have...we must have run out." He was asked if that meant not all residents were served eggs. He stated, "They should have fixed more, if that's what happened." He was asked about the condition of the scrambled eggs that were served to Resident #20. He stated, "They probably scraped them off of the bottom of the pan."

No further information was obtained prior to the exit conference on 03/01/2018.

F 880 SS=C Infection Prevention & Control
CFR(s): 483.80(a)(1)(2)(4)(e)(f) — F 880

§483.80 Infection Control
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and

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F 880	Continued From page 52	F 880		

comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

1. Infection control policy reviewed with MD, Administrator and DON.
2. Residents that reside in the facility have potential to be affected.
3. Processes reviewed monthly in infection control meeting.
4. Infection control reviewed monthly for 3 months in QAPI.
5. Date of completion 3/23/18.

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circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on review of the facility's Infection Control Program and staff interview, the facility failed to ensure an annual review of the program was conducted, and the program updated as needed.

The findings were:

At approximately 9:00 a.m. on 3/1/18, RN # 2 (Registered Nurse), the Infection Control Nurse, was interviewed during a review of the facility's Infection Control Program. Asked how often the Infection Control Program was reviewed and revised, RN # 2 said, "We have not done that. Any questions we have, we refer to Ms. (Name), the (facility) owner."

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F 880	Continued From page 54 At approximately 10:00 a.m. on 3/1/18, during a meeting that included the Administrator, Director of Nursing, a Unit Manager, the Infection Control Nurse, and the survey team, the lack of an annual review of the Infection Control Program was discussed. During the meeting it was learned the Infection Control Nurse has been in that position for about one year. It was also learned that the owner, Ms. (Name) was a Registered Nurse.	F 880		
F 881 SS=C	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of the facility's Infection Control Program and staff interview, the facility failed to ensure an Antibiotic Stewardship Program was include as part of the total Infection Control Program. The findings were: At approximately 9:00 a.m. on 3/1/18, RN # 2 (Registered Nurse), the Infection Control Nurse, was interviewed during a review of the facility's Infection Control Program. RN # 2 was asked if the facility had an Antibiotic Stewardship Program. "Not anything per se. All of the Infection Control Program is part of the Antibiotic	F 881	1. The antibiotic stewardship program has been revised to reflect clear defined steps of the stewardship program. This includes McGreer criteria, Epidemiology worksheet for root cause analysis, Loeb criteria reference and Loeb checklist. 2. Residents that reside in the facility have potential to be affected. 3. The DON/Designee will audit the infection control process weekly to ensure all steps are incorporated into the program.	

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Stewardship Program, but there is no separate program," RN # 2 said.

A thorough review of the Infection Control Program failed to identify any provisions directly related to protocols for the use and monitoring of antibiotics.

At approximately 10:00 a.m. on 3/1/18, during a meeting that included the Administrator, Director of Nursing, a Unit Manager, the Infection Control Nurse, and the survey team, the lack of an Antibiotic Stewardship Program was discussed.

4. Any issues will be discussed in the monthly/quarterly QAPI meeting and re-education will be given as needed to staff.
5. Date of completion 3/23/18.